For office use only:
_____ Payroll _____ Benefits

Input Date: _____

_____ Manual Check
_____ Payroll Deduct

ANTHEM BLUE CROSS BLUE SHIELD
EMPLOYEE HEALTH ENROLLMENT APPLICATION

Please complete in ink and return to your employer. Use extra sheets of paper if necessary.

Group Name: Stafford County Public Schools Group Number: 20397-_____ ❑ School Op ❑ Nutrition ❑ Fleet ❑ Head Start ❑

Retiree ❑ COBRA
Effective Date: (Mo/ Day/ Yr) _____ Date of hire: _____

EMPLOYEE INFORMATION – SECTION 1

Last name: _____ First name_____ M.I._____

Social security # _____ Date of birth (MM/DD/YYYY)_____ Sex: ❑ M ❑ F

Street address _____ Apt. # _____

City _____ State_____ Zip_____

Daytime phone (with area code) (_____)_____

Evening phone (with area code) (_____)_____

❑ Married
❑ Single

REASON FOR APPLICATION – SECTION 2

❑ Enroll / New ❑ Remove dependent ❑ Retiree / Carve out ❑ COBRA
❑ Change coverage ❑ Add dependent ❑ Retiree -Regular

PLAN SELECTION – SECTION 3

❑ KeyCare 100 ❑ KeyCare 15 ❑ KeyCare 30

TYPE OF COVERAGE – SECTION 4

❑ Employee only ❑ Employee / spouse ❑ Employee / one child
❑ Employee / children ❑ Employee / family ❑ Family – Husband / wife with SCPS

FAMILY INFORMATION – SECTION 5

*For additional children, include information on separate sheet of paper and attach to application. For a newborn without a social security number, please complete this application and provide the social security number, when obtained, to the Payroll and Benefits Department. * If a dependent is disabled or handicapped before age 23, please attach physician certification.*

Name (First, M.I., last if different)	**Relation** Son, daughter, stepson, etc.	**M / F**	**Social Security #**	**Date of Birth** MM/DD/YYYY	**Disabled** before age 23? Y / N *	**Full-time student?** Y / N
	Spouse					

OVER for side two and signature

MEDICARE COVERAGE – SECTION 6

If you or your dependents are enrolled in Medicare Part A, B & D complete the following for the covered individual(s).

Last name _____ **First name**_____ **M.I.** _____

HIC # _____

Effective Dates: Medicare Part A _____ Medicare Part B _____ Medicare Part D_____

- 65 or over: ❑ Working ❑ Retired
- Reason for Medicare Entitlement: ❑ Age ❑ Disability ❑ End Stage Renal Disease (ESRD) ❑ ESRD & Disability

Last name _____ **First name**_____ **M.I.** _____

HIC # _____

Effective Dates: Medicare Part A _____ Medicare Part B _____ Medicare Part D_____

- 65 or over: ❑ Working ❑ Retired
- Reason for Medicare Entitlement: ❑ Age ❑ Disability ❑ End Stage Renal Disease (ESRD) ❑ ESRD & Disability

Other Insurance Information – Section 7

Please list any health care plan/HMO that you or your family members have been covered by within the past 24 months including Anthem. List additional information on a separate sheet and attach it to the application.

Other carrier/plan name: _____ Policy/ID number: _____

Address of other coverage: _____

City: _____ State: _____ Zip: _____

Phone number of other carrier/plan: (_____)_____ Effective date (MM/DD/YY) _____

Policyholder name (Last, First, M.I.) _____

Please indicate whom this coverage applies to (check all that apply):

❑Self ❑Spouse ❑All Children ❑Child: Last Name _____ First Name _____

Do you intend to continue this coverage?

❑ Yes: Please provide policyholder's date of birth: _____ Type of coverage: ❑Health ❑Dental

❑ No: Please provide cancellation date of coverage: _____

EMPLOYEE CERTIFICATION – SECTION 8

I certify that I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage under the policy. I understand that it is discovered that I provided false or misleading information to Anthem Blue Cross Blue Shield within two years after the effective date of my coverage, Anthem may void my coverage without advance notice and refund my premium (less any claims paid) back to the effective date shown on this application, or may adjust the group's premium retroactively to my effective date. If the amount of benefits paid by Anthem exceeds the premiums paid, I agree to refund the excess amount to Anthem.

The employee and any person authorized to act on behalf of the employee, is entitled to receive a copy of this form and will be provided with a copy upon their request.

Employee Signature: _____ Date: _____